

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02710

CERTIFICATE OF DEATH

02720

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital Annex</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MOLLIE D. BOWEN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cabret County</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George W. Bowen Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr. Howard J. Pasche - Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MI</u> <u>792X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/29</u> , 19 <u>57</u> , to <u>3/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Prince Frederick</u> DATE SIGNED <u>PRINCE FREDERICK</u>							
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D. <u>PRINCE FREDERICK</u>							
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackman & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR <u>4-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. H. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 3 1957

RECEIVED

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE		ALABAMA		U.S.A.		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1948		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HIGH SCHOOL		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
BUSINESS		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE	
CAUSE OF DEATH		DISEASE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HEART DISEASE		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE	
MANNER OF DEATH		NATURAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
NATURAL		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE	
DATE OF DEATH		1968		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1968		MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE	
PLACE OF DEATH		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY		STATE	
MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE		ALABAMA	
CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MOBILE		ALABAMA		U.S.A.		U.S.A.		MOBILE		ALABAMA		U.S.A.		MOBILE		ALABAMA	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02711

CERTIFICATE OF DEATH

02721

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 1 Lushy Maryland			
3. NAME OF DECEASED (Type or print) Newborn Baby Brooks				4. DATE OF DEATH 3-10-57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Oliver Foote				14. MOTHER'S MAIDEN NAME Mildred Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/10 , 19 57 , to 3/10 , 19 57 that I last saw the deceased alive on 3/10 , 19 57 , and that death occurred at — M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Roberto de Villarreal M.D.				ADDRESS (Street, city or town, state) St. John DATE SIGNED 3/10			
PHYSICIAN'S NAME (Type) Dr. Roberto de Villarreal							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-11-57		22c. NAME OF CEMETERY OR CREMATORY St. John		22d. LOCATION (City, town, or county) (State) Calvert Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sawell ADDRESS Pr. Frederick Ind.				24a. REC'D BY REGISTRAR H. W. Ward DATE 3-11-57		24b. REGISTRAR'S SIGNATURE	

2064359XV4

RECEIVED
MAR 12 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02722

02712

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>-</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>Gross</u> Last <u>Gross</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-1913</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House-wife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>James Baragars</u>			
14. MOTHER'S MAIDEN NAME <u>Josephine Coates</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Lawrence Gross - St. Leonard, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Cervix, uteri.</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2/21</u> , 19 <u>57</u> , to <u>3/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page Jett</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>				DATE SIGNED <u>3/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooks M. Church</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy E. Berry</u>				ADDRESS <u>Huntingtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-18-57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

MAR 19 1957

RECEIVED

PLACE TO BE FILLED BY REGISTRAR		PLACE TO BE FILLED BY REGISTRAR	
NAME OF DECEASED		NAME OF DECEASED	
AGE		AGE	
SEX		SEX	
RACE		RACE	
DATE OF BIRTH		DATE OF BIRTH	
PLACE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
DATE		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02723	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										37	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willows			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 5601 Western Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle B. Last Herbert					4. DATE OF DEATH Month 3 Day 31 Year 19 57						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-1937		9. AGE (In years last birthday) 20 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Safeway Stores Inc.			11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Earl T. Herbert					14. MOTHER'S MAIDEN NAME Lula Clubb						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 578-48-0676		17. INFORMANT Earl T. Herbert			Address 5601 Western Ave Wash. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoperitoneum 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) gunshot wound of lower left abdomen (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by a friend during a shooting game							
20c. TIME OF INJURY Month, Day, Year 12:30 3 31 1957 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) Willows		(County) Calvert		(State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE R. S. Fisher					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 4-1-57	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			22d. LOCATION (City, town, or county) (State) Silver Spring, Mont. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins					ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR APR 5 1957		24b. REGISTRAR'S SIGNATURE Elmer Cox		
Francis J. Collins 3821 14th. St. N.W.											

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 5 1957

RECEIVED

02714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence, before admission) o. STATE <i>Md</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fruitlyn</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Fruitlyn</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Holland</i> Middle <i>Lee</i> Last				DATE OF DEATH 3 / 7 / 19 57			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7</i>	9. AGE (In years last birthday) <i>83 1/2</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Hall</i>				14. MOTHER'S MAIDEN NAME <i>Rachel Holland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alburt Leid, Fruitlington Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cere</i> (c) <i>Cere</i> DUE TO cause listed. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Found dead in bed</i>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. City or town (County) (State) <i>Fruitlyn Cecil Md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>H. W. Ward</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5-9-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Paluxent-</i>		22d. LOCATION (City, town, or county) (State) <i>Fruitlington Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell Pr. Fred Ind</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>3-9-57</i>	
						24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02715 Item 9 FilmG212 3-28-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

02725
Reg. Dist. No. 51

1. PLACE OF DEATH o. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>California 18x22</u>		d. STREET ADDRESS <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emmie</u> First Middle Last <u>Livingston</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1877</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Haele</u>				14. MOTHER'S MAIDEN NAME <u>Annie Haele</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Charles B. Livingston - California - Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiac vascular disease</u> <u>442x</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Jan</u> , 1957, to <u>12 Mar</u> , 1957, that I last saw the deceased alive on <u>10 Mar</u> , 1957, and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. J. Weems</u>				M.D. <u>Huntingtown, Md</u> DATE SIGNED <u>12 Mar 57</u>			
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>				<u>HUNTINGTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley - Leonardtown, Md</u>				24b. REC'D BY REGISTRAR DATE <u>3-13-57</u>		24c. REGISTRAR'S SIGNATURE <u>H. Ward</u>	

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02726

02716 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Essie</u> First <u>Albert</u> Middle <u>Linn</u> Last <u>Sims</u>				4. DATE OF DEATH <u>March</u> Month <u>30</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alvin Sims</u>				14. MOTHER'S MAIDEN NAME <u>Mary Linn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1918</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mary Sims, Prince Frederick</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease</u> <u>442X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac disease. Found dead in bed</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H W Ward</u> M.D.				ADDRESS (Street, city or town, state) <u>Owings Md</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. (BURIAL, CREMATION, REMOVAL) (Specify)		22b. DATE THEREOF <u>Apr. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Browns.</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Seewell</u>				ADDRESS <u>Prince Fred, Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-1-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>H W Ward</u>			

CERTIFICATE OF DEATH

MD-100 (Rev. 1-55)

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. OCCUPATION [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. MANNER OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF PHYSICIAN [REDACTED]	
16. SIGNATURE OF CORONER [REDACTED]		17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JUDGE [REDACTED]	
19. SIGNATURE OF CLERK [REDACTED]		20. SIGNATURE OF REGISTRAR [REDACTED]		21. SIGNATURE OF ARCHIVIST [REDACTED]	
22. SIGNATURE OF [REDACTED]		23. SIGNATURE OF [REDACTED]		24. SIGNATURE OF [REDACTED]	
25. SIGNATURE OF [REDACTED]		26. SIGNATURE OF [REDACTED]		27. SIGNATURE OF [REDACTED]	
28. SIGNATURE OF [REDACTED]		29. SIGNATURE OF [REDACTED]		30. SIGNATURE OF [REDACTED]	
31. SIGNATURE OF [REDACTED]		32. SIGNATURE OF [REDACTED]		33. SIGNATURE OF [REDACTED]	
34. SIGNATURE OF [REDACTED]		35. SIGNATURE OF [REDACTED]		36. SIGNATURE OF [REDACTED]	
37. SIGNATURE OF [REDACTED]		38. SIGNATURE OF [REDACTED]		39. SIGNATURE OF [REDACTED]	
40. SIGNATURE OF [REDACTED]		41. SIGNATURE OF [REDACTED]		42. SIGNATURE OF [REDACTED]	
43. SIGNATURE OF [REDACTED]		44. SIGNATURE OF [REDACTED]		45. SIGNATURE OF [REDACTED]	
46. SIGNATURE OF [REDACTED]		47. SIGNATURE OF [REDACTED]		48. SIGNATURE OF [REDACTED]	
49. SIGNATURE OF [REDACTED]		50. SIGNATURE OF [REDACTED]		51. SIGNATURE OF [REDACTED]	
52. SIGNATURE OF [REDACTED]		53. SIGNATURE OF [REDACTED]		54. SIGNATURE OF [REDACTED]	
55. SIGNATURE OF [REDACTED]		56. SIGNATURE OF [REDACTED]		57. SIGNATURE OF [REDACTED]	
58. SIGNATURE OF [REDACTED]		59. SIGNATURE OF [REDACTED]		60. SIGNATURE OF [REDACTED]	
61. SIGNATURE OF [REDACTED]		62. SIGNATURE OF [REDACTED]		63. SIGNATURE OF [REDACTED]	
64. SIGNATURE OF [REDACTED]		65. SIGNATURE OF [REDACTED]		66. SIGNATURE OF [REDACTED]	
67. SIGNATURE OF [REDACTED]		68. SIGNATURE OF [REDACTED]		69. SIGNATURE OF [REDACTED]	
70. SIGNATURE OF [REDACTED]		71. SIGNATURE OF [REDACTED]		72. SIGNATURE OF [REDACTED]	
73. SIGNATURE OF [REDACTED]		74. SIGNATURE OF [REDACTED]		75. SIGNATURE OF [REDACTED]	
76. SIGNATURE OF [REDACTED]		77. SIGNATURE OF [REDACTED]		78. SIGNATURE OF [REDACTED]	
79. SIGNATURE OF [REDACTED]		80. SIGNATURE OF [REDACTED]		81. SIGNATURE OF [REDACTED]	
82. SIGNATURE OF [REDACTED]		83. SIGNATURE OF [REDACTED]		84. SIGNATURE OF [REDACTED]	
85. SIGNATURE OF [REDACTED]		86. SIGNATURE OF [REDACTED]		87. SIGNATURE OF [REDACTED]	
88. SIGNATURE OF [REDACTED]		89. SIGNATURE OF [REDACTED]		90. SIGNATURE OF [REDACTED]	
91. SIGNATURE OF [REDACTED]		92. SIGNATURE OF [REDACTED]		93. SIGNATURE OF [REDACTED]	
94. SIGNATURE OF [REDACTED]		95. SIGNATURE OF [REDACTED]		96. SIGNATURE OF [REDACTED]	
97. SIGNATURE OF [REDACTED]		98. SIGNATURE OF [REDACTED]		99. SIGNATURE OF [REDACTED]	
100. SIGNATURE OF [REDACTED]		101. SIGNATURE OF [REDACTED]		102. SIGNATURE OF [REDACTED]	

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Reg. Dist. No.

51

02717

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

BACK OF CARD TO BE FILLED BY THE REGISTRAR IN THE OFFICE OF THE REGISTRAR OF THE DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		MARYLAND DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	
NAME OF DECEASED (Print name in full) _____		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
DATE OF BIRTH (Month, day, year) _____		PLACE OF BIRTH (City, State, Country) _____	
DATE OF DEATH (Month, day, year) _____		PLACE OF DEATH (City, State, Country) _____	
TIME OF DEATH (Hour, minute) _____		CAUSE OF DEATH (List all causes, beginning with immediate cause) _____	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined) _____		SIGNATURE OF REGISTRAR _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____	
SIGNATURE OF JUDGE _____		SIGNATURE OF CLERK _____	

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